

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS358AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2009
NAME OF PROVIDER OR SUPPLIER SAN VICENTE HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 8460 RANCHO DESTINO RD LAS VEGAS, NV 89123		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 8/6/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 10. Ten resident files were reviewed and five employee files were reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 895 SS=C	449.2744(1)(b)(1) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of	Y 895		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS358AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2009
NAME OF PROVIDER OR SUPPLIER SAN VICENTE HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 RANCHO DESTINO RD LAS VEGAS, NV 89123		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 994	<p>Continued From page 2</p> <p>Based on observation on 8/6/09, the facility failed to ensure dangerous items were kept inaccessible to 10 of 10 residents (Sharp, pointed scissors were stored in a cup with pencils and pens on the kitchen counter directly below the medicine cabinet. Though the caregiver reported residents were not allowed in the kitchen, there was an entrance to the kitchen from the dining room/family room area that was not secured or provided a door).</p> <p>Severity: 2 Scope: 3</p>	Y 994			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.